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## **SMALL BUSINESS/YOUNG ADULT HEALTH REFORM POLICY PROPOSAL**

### **Preparations for the 2009 Legislative Session – KHPA Discussions on Health Care Reform Options**

The dialogue with the SBHISC yielded a plethora of recommendations from various stakeholders within the small business market; Kansas Insurance Department, health plan administrators, independent agents, and advocates. From the start, there were common themes in the responses from all participants, focusing primarily on affordability and cost containment. Both of these issues are interrelated, as in order for affordability to be sustained for any significant period of time, pressure from increasing costs must be relieved. The process considering various options for reform was comprehensive, but the feedback from the SBHISC as well as direction from the 2008 Legislative Session was for KHPA and its recommendations to be more focused for 2009. As a result, KHPA and srHS crafted the following reform options to model for the 2009 Legislative Session:

#### **Proposal 1**

- Young Adults – Allow all Dependent Young Adults from 19-25 remain on Parent's Insurance Coverage

#### **Proposal 2**

- Mini-Med – Estimate cost and enrollment due to offering Mini-Med policies
- Reinsurance – Estimate cost of Subsidized Reinsurance to reduce cost and volatility of Small Employer Health Insurance Market

#### **Proposal 3**

- Business Health Partnership (BHP) – Expand roles and responsibilities of BHP in leading Small Employer Reforms
- Section 125 – Mandate Section 125 Plans for all Small Employers

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### Proposal 1

#### *Allowing all dependent young adults from 19-25 to remain on their parent's insurance coverage*

Young adults are, in general, healthier than their older counterparts and may see less benefit in paying top dollar for comprehensive health insurance plans. A change in Kansas insurance law to allow parents to keep young adults on their family insurance plan through age 25 would assist in providing transitional insurance to young adults as they leave home, enter the workforce, and gain employer-sponsored coverage.



## Reforms Modeled – Plan Design: Young Adults

### Cost and Eligibles for Young Adults Remaining with Parents Coverage:

Range of Eligibles and Cost for Uninsured Young Adults 19-25 Estimated Additional Premium Costs to Overall Health Market				
	High Eligibles	Low Eligibles	High Cost	Low Cost
Adults 19-25 Remaining with Parents Coverage	28,000	21,000	\$ 72,240,000	\$ 54,000,000

\*Assumes a standard benefit package

\*\*Assumes the uninsured have the same average risk profile as the insured

\*\*\*Assumes 100% take up (everyone eligible for coverage under these changes enrolls)

Last year this proposal applied to the State Employee Health Plan had a fiscal note of \$5.9 million to extend coverage to dependents.

### Staff Recommendations:

Allowing dependents to continue to be covered on their parent's health insurance policy up to age 26 would reduce the number of uninsured young adults but cost estimates indicate the policy is costly.

## ***Proposal 2***

***Restructure the Small Business Health Policy Committee to assist small employers to secure health insurance, allowing very small employers to obtain health insurance and making health insurance more affordable for small businesses and employees to expand affordable commercial insurance.***

Schramm-raleigh Health Strategies examined the existing Kansas statutes governing the small employer insurance market and previous attempts to reform the small employer health insurance market in Kansas. In a notable previous move to address uninsurance in the small employer market in Kansas, the Legislature created the Business Health Partnership. As an existing statutory vehicle, the Partnership, could provide a ready vehicle for any reform efforts and potentially shorten the time to implementation for any reform proposals.

### **The Business Health Partnership**

The Business Health Partnership (BHP) does offer stakeholders an existing legislative vehicle that could support several of the proposed reforms in the small group market without change; however some of the propositions do require amendments to the current statute.

As noted by the stakeholders, it would be desirable to utilize the BHP as a vehicle allowing multiple employers and funding sources to contribute to an employee's health insurance costs. The BHP is currently authorized to combine funds from the federal government and the state, with contributions from employers and their employees to purchase health insurance. In addition to being authorized to accept funds, the BHP also has the ability to offer Mini-Med policies, and it would not be subject to all of the health insurance benefit mandates in Kansas, however there are mandates in the BHP legislation that mandate preventive and screening services, which must be included in any policy offered.

### **Potential Changes to BHP Statute**

There are some slight changes needed if the BHP were to offer the Mini-Med policy as currently proposed.

- The Mini-Med proposal includes a 6-month "go-bare" provision, essentially stating to be eligible for enrollment one would have had been without insurance for the previous 6 months. In the statute the BHP cannot offer its products to any business that has offered health insurance, or contributed to the cost of coverage for its employees for the previous 2 years.
- The second area of difference between proposed policy and current statute regards what is considered a full-time employee in order to be eligible for policies offered by the BHP. While the statute currently requires an employee work at least 30 hours per week to be eligible for coverage, the Mini-Med proposal requires only 20 hours per week, to allow workers who may work part time at two or more jobs to still have the opportunity to participate.

### **Potential Additional Roles of the BHP**

In addition to offering health insurance policies to small employers, the BHP has the potential to serve multiple purposes in serving the small group market.

The BHP can take an active role in product design, ensuring quality affordable products for small employers. There are many components to this role, such as developing benefits and pricing for new products, and the development, marketing, and evaluation of RFP's for carriers to provide pricing on BHP products. The BHP could also develop service specifications for Section 125 vendors, and facilitate the development, marketing, and evaluation of RFP's for Section 125 services.

In an administrative capacity the BHP could act as a resource for small employers purchasing health insurance, regardless if the policy being purchased is offered by the BHP or not. In this situation the

BHP would provide a Seal of Approval for certain products and carriers they have deemed quality affordable insurance products, as well as play a similar role as it relates to Section 125 services and the mandate for small employers accessing health insurance through the BHP to establish a Premium only 125 plan. The BHP could also coordinate the receipt and distribution of money from different funding sources on the employer's behalf.

#### Staff Recommendations

There are numerous potential approaches that Kansas could consider to reform the small employer health insurance market in Kansas. The BHP as it is currently written into statute is able to facilitate most of the reform proposals for the small group market, being able to offer insurance products and combine subsidies from state and federal funding sources. However, there may need to be changes made to the statute concerning the eligibility requirements for employers and employees that would more closely align with the goals of the reform proposals considered. These changes were generally favored by the stakeholders that participated in the Small Business Health Insurance Steering Committee. Additionally, potential regulatory roles of the BHP would have to be examined much more closely to ensure there is no overlap with the proposed duties and those currently being performed by other state agencies.

### **Proposal 3**

#### ***Allowing insurers to offer young adult policies with limited benefits and reduced premiums to expand access to affordable coverage***

Schramm<sup>®</sup>raleigh Health Strategy (srHS) priced out a “Mini-Med” plan design and modeled the impact on the number of uninsured young adults (ages 18-25) in Kansas by allowing insurers to offer policies specific to young adults with limited benefits and reduced premiums. Premiums calculated reflected both the limited benefits and the underlying health risk for young adults. Based on the lower monthly premium and subsidies from the State srHS estimated how many additional young adults would purchase health coverage.

#### **Mini-Med: Young Adult Limited Benefit Health Coverage**

In contrast to the majority of products seen in the health insurance market, Mini-Med is not and should not be considered health insurance, but rather health coverage. In this instance Mini-Med is intended to provide an affordable alternative for access to coverage through traditional sources in the private market. In order to prevent crowd-out from the private market and to target the uninsured srHS is assuming a 6 month “go-bare” provision, making a requirement for eligibility that enrollees have been uninsured for 6 months prior to enrollment. The Mini-Med plan has the following service specific dollar amount and service limitations:

Benefit	Limit (for a 12 month period)	Cost Share
Doctor Visits	12 Visits	
• PCP		\$15 Co-Pay
• Specialist		\$25 Co-pay
Prescription Drugs	Generic Only \$2,000 Maximum	\$10 Co-Pay
Inpatient	\$15,000 Maximum	\$100 Co-Pay
Emergency Room	2 Visits	\$50 Co-Pay
Outpatient Surgery	1 Visit	\$25 Co-Pay
Outpatient Other (Includes Lab/Radiology and PT/ST/OT services)	4 Services	\$25 Co-Pay
DME	\$1,000 Limit	\$0 Co-Pay
Maximum Annual Benefit	\$25,000	

#### **Access and Affordability**

The Mini-Med product is able to offer coverage at approximately \$122 per month, which is roughly 20% less than the cost of the typical insurance product purchased on the individual market, however with no deductibles or coinsurance. When comparing the premiums of Mini-Med and employer sponsored insurance (ESI), ESI is less expensive due to the employer typically covering 70%-80% of premium expense. Despite the economic advantage of purchasing ESI, young adult participation in ESI is low for two reasons:

1. The transient nature of employment seen in the young adult population typically does not allow them to be eligible for coverage through an employer; and
2. Many do not have employers who offer insurance or are willing to contribute its cost.

Even though in comparison to other policies Mini-Med is more affordable, it is not likely there will be a large portion of the uninsured young adults purchasing a Mini-Med program at full price. This can be explained by the large number of young adults that are considered either low income or are living under the Federal poverty level (FPL). People with lower income place more value to each dollar relative to their higher earning counterparts, therefore a 20% decrease in premium does not increase their propensity to purchase coverage if the resulting premium is still a significant portion of their monthly income. To address this issue srHS modeled

the effects of a state subsidy for the premiums in this plan. Assuming state subsidization, enrollee contributions would range from \$5 to \$45 depending on income. srHS used an elasticity of demand function in an attempt to estimate how many of the uninsured young adults would purchase the Mini-Med product based on:

1. The current purchasing decisions of this population; and
2. The out of pocket expenditures associated with Mini-Med (includes both premium contribution and cost sharing).

Due to the factors listed above regarding the unlikely nature of uninsured young adults to purchase coverage, their demand was assumed to be relatively inelastic. The majority of studies done regarding elasticity of demand as it relates to health insurance state the average figure to be between  $-.500$  and  $-.600$ , which would be considered inelastic. These studies have typically not targeted young adults, but the limited information available suggests this group to be more inelastic than their older counterparts, so to be conservative we assume a base elasticity of  $-.100$ .

The modeling results showed that the number of uninsured young adults could be reduced using state subsidies. Due to the inelastic nature of young adults as it relates to purchasing health coverage, a significant reduction in price is necessary to provide enough incentive to purchase coverage. Assuming state subsidization as stated above, it is estimated over 8,000 previously uninsured young adults would purchase Mini-Med coverage, showing a 10% uptake of the eligible population. In addition, approximately 25% of new enrollment would come from those under the poverty level, and almost 70% would be those making less than 300% (FPL).

State subsidization of this program would cost the state \$7,000,000 or about \$70 per enrollee, which, in relation to typical state subsidized coverage, is cost effective.

## Reforms Modeled – Plan Design: Mini-Med

### Structure of Mini-Med Subsidization and Estimated Costs:

FPL Ranges		New Enrollment	Enrollee Share (PMPM)	Employer (PMPM)	State Share (PMPM)	Annual Cost to the State
0%	50%	500	<b>\$5</b>	\$56	<b>\$107</b>	\$592,000
50%	100%	700	<b>\$10</b>	\$56	<b>\$102</b>	\$865,000
100%	150%	1,300	<b>\$15</b>	\$56	<b>\$97</b>	\$1,473,000
150%	200%	1,500	<b>\$25</b>	\$56	<b>\$87</b>	\$1,566,000
200%	250%	1,500	<b>\$35</b>	\$56	<b>\$77</b>	\$1,355,000
250%	300%	1,600	<b>\$45</b>	\$56	<b>\$67</b>	\$1,252,000
300% and Above		4,000	<b>\$84</b>	<b>\$84</b>	<b>\$0</b>	\$0
Totals		11,000				\$7,103,000

\*Red Bolded Numbers in Employee Share Reflect State Subsidy

\*\*Bolded Numbers in State Share Column Reflect 1/3 Share and Subsidy

Adding a layer of targeted reinsurance to the Mini-Med policy would both reduce cost and volatility of the small employer health insurance market and cover catastrophic medical costs for individuals with those policies.

## Reforms Modeled – Plan Design: Mini-Med plus Targeted Reinsurance

### Cost and Enrollment of Mini-Med plus Targeted Reinsurance Program (\$30k stop-loss for Less than 150% FPL):

		Distribution of Cost by Funding Source		
New Enrollment Due to Mini-Med	~11,000	State Share	Employer Share	Employee Share
Mini-Med Cost	\$21,993,000	\$7,103,000	\$8,625,000	\$6,265,000
Low-Income RI	\$ 1,291,000	\$ 1,291,000	\$ -	\$ -
Total Cost	\$ 23,284,000	\$ 8,394,000	\$8,625,000	\$6,265,000

#### Staff Recommendations

This product operates under the principle that some coverage is better than no coverage. An individual who is uninsured seldom has regular access to a physician; this situation has the potential to lead to more serious health conditions. Mini-Med addresses this by making access to coverage affordable, allowing people to receive medical treatment as needed. An additional benefit to this policy would be showing young adults the value of health coverage, which can be useful in educating young adults new to the health insurance market. Taking a long-term approach is necessary in teaching future generations the importance having and utilizing health coverage. However, there is not universal agreement on the effectiveness of Mini-Med. The fact that there are limited benefits exposes enrollees to bear the risk of claims over \$25,000, which could leave them without coverage when the most serious medical conditions occur unless the reinsurance layer is added.